SENATE BILL 3095
By Stewart

HOUSE BILL 3317

By Matheny

AN ACT to amend Tennessee Code Annotated, Title 56, relative to autism.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-2367, is amended by deleting the section in its entirety and by substituting instead the following:

56-7-2367.

(a) As used in this section:

(1) "Autism spectrum disorder" means one (1) of the three (3) following disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:*

(A) Autistic Disorder;

(B) Asperger's Syndrome; or

(C) Pervasive Developmental Disorder - Not Otherwise Specified;

(2) "Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer. "Health insurance plan" includes the state health plan, but does not otherwise include any health insurance plan offered in the individual market as defined in § 56-7-2802, any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer, as defined by § 56-7-2802;

(3) "Health maintenance organization" means an organization as defined in § 56-7-2802(17);

(4) "Insurer" means an insurance company, a health maintenance organization, and any other entity providing health insurance coverage, as

defined in § 56-7-2802, which is licensed to engage in the business of insurance in this state and which is subject to state insurance regulation; and

(5) "State health plan" means the employee and retiree insurance program provided for in title 8, chapter 27.

(b) A health insurance plan as defined in this section must provide coverage for the treatment of autism spectrum disorder. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan. With regard to a health insurance plan as defined in this section an insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual solely because the individual is diagnosed with autism spectrum disorder.

(c) The coverage required pursuant to subsection (b) must not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health insurance plan, except as otherwise provided for in subsection (e). However, the coverage required pursuant to subsection (b) may be subject to other general exclusions and limitations of the health insurance plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

(d) The treatment plan required pursuant to subsection (b) must include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, proposed treatment by type,

frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature. The health insurance plan may only request an updated treatment plan once every six (6) months from the treating medical doctor to review medical necessity, unless the health insurance plan and the treating medical doctor agree that a more frequent review is necessary due to emerging clinical circumstances.

(e) To be eligible for benefits and coverage under this section, an individual must be diagnosed with autistic spectrum disorder at eight (8) years of age or younger. The benefits and coverage provided pursuant to this section must be provided to any eligible person under sixteen (16) years of age. Coverage for behavioral therapy is subject to a fifty thousand dollar ($50,000) maximum benefit per year. Beginning one (1) year after the effective date of this act, this maximum benefit shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the current Consumer Price Index, All Urban Consumers, as published by the United States Department of Labor's Bureau of Labor Statistics.

SECTION 2. This act shall take effect July 1, 2010, the public welfare requiring it and apply to health insurance plans issued, renewed, delivered, or entered into on or after that date.